Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP)
Physical Medicine and Rehabilitation (PM&R)
Minneapolis VA Health Care System (MVAHCS)

Introduction

PROGRAM OVERVIEW

The MVAHCS PM&R CIIRP is an inpatient, interdisciplinary, acute rehabilitation program for survivors of serious injury or illness. Patients are admitted with a range of etiologies and diagnoses and the CIIRP offers specialized programming in *Amputation*, *Stroke*, and *Brain Injury (BI)* rehabilitation. Patients with historical connections to the CIIRP may be admitted for brief respite stays.

CIIRP services are provided by licensed and credentialed rehabilitation professionals (**Table 1.)** The interdisciplinary rehabilitation team includes the person served and his/her support circle, service providers in Table 1 and hospital consultants as needed, and external stakeholders as appropriate. Programming is designed to pursue goals and outcomes defined by persons served.

The BI specialty program within the CIIRP is part of the PM&R BI rehabilitation continuum in partnership with the BI specialty programs in our Polytrauma Transitional Rehabilitation program and our outpatient BI rehab program. The CIIRP BI program serves as the upper Midwest Polytrauma Rehabilitation Center (PRC) in the VHA polytrauma/TBI System of care. The CIIRP Amputation specialty program serves as the North Central Regional Amputation Center (RAC) within the VHA Amputation System of Care. More information can be found at http:/minneapolis.va.gov/services/pmr.

The CIIRP is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) for Inpatient Medical Rehabilitation and Amputation, Stroke, and BI rehabilitation specialty programming. The current accreditation term runs through May 2015.

PURPOSE OF THIS DOCUMENT

This document provides a description of MVAHCS PM&R CIIRP and the three co-housed specialty programs. This version was written in late 2012 and is based on 2012 CARF Medical Rehabilitation standards.

MORE INFORMATION

More information about MVAHCS PM&R programming, including the CIIRP can be found at the "Programs and Services" page of the Minneapolis URL listed above. This information includes the most recent "Year in Review" pdf that provides participant demographics and program outcomes. Specific questions can be directed to the CIIRP intake coordinator via stacy.tepper2@va.gov.

Chaplaincy	Recreation Therapy
Low Vision Rehabilitation	*Rehabilitation Engineering
Internist/Hospitalist	Rehabilitation Nursing
Neuropsychology	Rehabilitation Psychology
Nutrition/Dietetic services	Social Work
*Occupational Therapy (includes Driving assessment and training)	*Speech-Language Pathology
Pharmacy, including PharmD onsite consultation	Vocational Rehabilitation and counseling
*Physiatry (M.D. or D.O)	Other Consultative Services (e.g. Audiology, ENT, Orthopedics, Neurology, Neurosurgery, Ophthalmology and Neuro-ophthalmology, Plastic Surgery, etc.)
*Physical Therapy	
Prosthetics/Orthotics	
Psychiatry (M.D.)	

Table 1: Interdisciplinary team members and array of services provided. Team participants are either direct members of PM&R (*) or are involved via service agreements or via the intra-facility consult system.

Parameters

Characteristics of populations served	We serve male and female, Veteran and Active Duty Service Members (ADSM). Most have recent onset rehabilitation needs related to Amputation (limb loss re: chronic disease or polytrauma), Stroke, or BI.
Settings	Services are provided on the 18 bed unit, in and on the grounds of the medical center, or in the community.
Days and Hours of Service	Rehabilitation nursing and medical services are provided 24 hours per day, 7 days per week. Allied therapy services are available M-F. Weekend therapeutic services are offered through condensed scheduling.
Frequency of services	Services are offered per rehabilitation needs and personal goals and can vary between patients and over a specific patient's length of stay.
Payer sources	Veterans are covered through the VHA eligibility system. ADSM's are covered under a Memorandum of Agreement with the Department of Defense (DoD.)
Fees	Fees are calculated per individual Means Tests. Fee information is shared via a Rehab Disclosure Statement provided near admit. Case managers can facilitate meetings between persons served and the Business Office for further discussion.
Referral Sources	Referrals are from MVAHCS, other VA Medical Centers, the DoD, and community providers.
Specific services offered	We provide or coordinate all therapeutic, medical, and surgical services required by persons served. *Amputation:* Admission may be for pre-prosthetic training, initial prosthetic fitting and training, or for timed-interval re-admissions for specific prosthetic follow-up. *Brain Injury:* Specialized programming includes our *Emerging Consciousness (EC)* program for severely injured patients with disorders of consciousness.

Table 2: Scope of service parameters

Age	Young adult to geriatric.
Activity limitations	Limitations range from complete physical and/or cognitive dependence to independence.
Behavioral or psychological status	Individuals who pose a danger to themselves or others are deferred to a more appropriate setting of care.
Cultural needs	Services and treatment support cultural, religious, gender, age, and other interests and beliefs. Customization of patient rooms is supported.
Impairments	Changes in body structures or functions include BI, limb loss, hearing loss, vision loss, and orthopedic injuries.
Intended discharge environments	Targeted discharge is to an environment that supports the greatest possible degree of independence and social inclusion/participation possible.
Medical acuity	The CIIRP is able to provide or coordinate care for acutely ill patients, though increased acuity may require an alternate rehabilitation plan in an alternate nursing unit. The CIIRP does not admit patients who are ventilator dependent. *Amputation:* Those admitted may be in the acute phase of recovery following amputation. Planned admits are screened via infection control parameters which may impact elements of care (contact precautions, single room assignments, etc.) Positive screening does not preclude admission.
Medical stability	Patients must have sufficient medical stability to tolerate their planned rehabilitation program. *Amputation:* For prosthetic training, stability includes the readiness of the residual limb (e.g. adequate incision healing post surgery.)
Participation restrictions	Some patients are fully dependent on others while others are able to leave the grounds via passes with family members. Those admitted are deemed capable of participating in community integration programming and community-based excursions as feasible.

Table 3: Parameters of persons served

Specific Arrangements for non-PM&R Services

	Availability on site	*Capacity*	*Timeliness of response to orders*	*Timeliness of response to the clinician who placed the orders*
Medical services	Yes	Unlimited	Based on urgency, within 24 hours for inpt care.	Within 24 hours.
Diagnostic imaging	Yes	Unlimited	Based on urgency. Average timeframe is 1 hour or less. A proactive phone call to Imaging supervisor is required for STAT requests on evenings, weekends, and holidays.	Based on urgency. After exam is completed, results are entered in CPRS within 15 minutes to 2 hours.
Laboratory services	Yes	Unlimited	Based on urgency.	Based on tests ordered. Critical results are called to the provider emergently.
Pharmacy services	Yes	Unlimited	30 minutes or less.	30 minutes or less.

Table 4: Availability of non PM&R, in-house services for all CIIRP patients.

Criteria and Process Descriptions

ADMISSION CRITERIA

1. Have sufficient medical stability to allow transport to and management on the rehab unit.
2. Have rehab needs appropriate for an acute rehabilitation program (i.e. don't have rehab needs that can be met at a lower level of care).
3. Require direct, daily, contact with rehabilitation physicians and nursing services.
4. Require the services of an interdisciplinary team (IDT) for evaluation and treatment.
5. Have a recognized legal decision maker if lacking capacity of self-autonomy for planning and legal processing (e.g.: DoD, guardian, legal next of kin.)
6. Have a reasonable expectation for improvement and discharge to a less restrictive environment of care.
7. Have no behavioral impairments that preclude care on an open (i.e. unlocked) unit.
8. Have rehab needs that are best met or coordinated by PM&R services rather than Behavioral/Mental Health services.

DEFERRAL CRITERIA

Absence of any of the Admission Criteria is grounds for deferral of admission. These are defined as:

1. Medical instability
2. Rehab needs can be met at a lower (i.e. less intense) level of care
3. Absence of need of direct, daily Rehab Physician or nursing services
4. Absence of need for interdisciplinary rehab treatment
5. Absence of a legal decision maker
6. Absence of reasonable expectation for improvement
7. Presence of behavioral impairments that are incompatible with an unlocked unit
8. Primary focus of care is best provided in a Mental Health setting
9. Other

TREATMENT PROCESS AND CONTINUING STAY CRITERIA

Each person's rehabilitation program is based on an interdisciplinary assessment of individual strengths, impairments, limitations, restrictions, medical problems, resources, interests and preferences. Each individualized program is reviewed and modified as necessary across the span of admission.

Key points across each admission include:

1. Initial goal setting
    a. Following the assessment, the IDT team meets to establish a treatment plan.

- Goals of the person served are incorporated into the treatment plan
- Discipline-specific and Interdisciplinary Short term and long term goals are set.
- Predictions are made for length of stay, discharge disposition, and level of function at discharge.

b. The treatment plan and predictions are discussed with the person served.

2. Reevaluation
   a. Progress on treatment goals is measured by the IDT, the person served, and family members.
   b. IDT rounds are held weekly or biweekly, as appropriate. Areas of discussion include:
      - Assessment of current function
      - Progress towards goals
      - Barriers to progress
      - Review of resources
      - Review of length of stay
      - Review of discharge plans
      - Review of goals of the person served
      - Review of educational needs for the person served and family member.

DISCHARGE PROCESS AND CRITERIA

1. When the person served has reached his/her goals, is no longer making progress, or is no longer able to participate in the program, arrangements for discharge are made.
2. The decision to discharge is made in collaboration with the person served, the family, and other stakeholders as appropriate.
3. Discharge planning is done in a coordinated fashion with all members of the IDT. Available resources, ongoing care requirements, and long term needs are considered.
4. Clinical follow up is arranged either through MVAHCS outpatient services or in the discharge community
5. Discharge plans are summarized in a written discharge summary. Social Work, nursing, and discipline-specific discharge summaries are also written.
6. Following discharge, continuity of care is arranged by the case manager(s). This may include:
   a. Outpatient care by the current PM&R team members
   b. Outpatient care by different PM&R staff or by VA or local providers in the home community.
   c. Admission to a Transitional Rehabilitation program, subacute/extended care setting, or nursing home.
   d. Referral to community agencies

Performance Measurement and Management System

The CIIRP operates under the direction of the Medical Director in connection with the Medical Directors of the specialty programs, Nursing service, and the various PM&R departments. Program performance is evaluated regularly on an established set of parameters as well as ad-hoc reviews of unexpected situations or incidents.

Status reviews, performance improvement projects, and other discussions are held in monthly meetings of the CIIRP Rehab Standards work group. New developments are shared with PM&R leadership through the weekly PM&R Huddle and with MVAHCS Executive Leadership through a monthly Front Office Focused Briefing. CIIRP leaders are in regular conversation with leadership of the MVAHCS Extended Care and Rehabilitation Patient Service Line (EC&R PSL), Veterans Integrated Service Network 23 (VISN), and VHA Polytrauma and PM&R Central Office.

Outcomes and Measurement documents of interest to PM&R staff are posted on the PM&R SharePoint. Documents of interest to the general public are posted on the PM&R pages of the MVAHCS Web site.

Key discussions and Formal Reports include:

1. Access, including deferral rates and reasons, occupancy rates, average numbers of treatment hours, and lengths of stay
2. Patient demographics
3. Accessibility Review and Risk Mitigation
4. Effectiveness and efficiency outcomes via Functional Independence Measures (FIM)
5. Falls monitoring
6. Infection control
7. Disruptions in care
8. Medical records reviews for adequate documentation
9. Success at predicting outcomes for discharge status
10. Pressure ulcers
11. Restraint use
12. Stakeholder satisfaction

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